Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY IMAGING CENTER

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-17-0376-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received denial based on we need to verify time for Sedation Codes. We mailed two request for reconsideration veifying the time. The requests for reconsideration was denied. Please assist us obtaining final adjudication on the claim."

Amount in Dispute: $164.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation provided in the procedure report is not fufficient to support codes 99144 and 99145. The intra-service time documenting the time the sedation agent(s) were given and the end of procedure time are not supported in the documentation."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2016	CPT Code 99144	$110.00	$0.00
	CPT Code 99145	$54.00	$0.00
TOTAL		$164.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X164-Verify time for this procedure and resubmit claim.

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.

Issues

Does the documentation support billed service? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for CPT codes 99144 and 99145 based upon reason codes "X164-Verify time for this procedure and resubmit claim," and "150-Payment adjusted because the payer deems the information submitted does not support this level of service."

Per 28 Texas Administrative Code §134.203(a)(5), "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

The requestor is seeking medical fee dispute resolution for CPT codes 99144 and 99145. The codes are defined as follows:

- 99144- Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time.
- Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service).

Medicare Policy Manual 100-04, Transmittal 1324, Change Request 5618, effective October 1, 2007 Subsection B states**:**

> Policy: The anesthesia payment policy in Pub. 100-04, chapter 12, section 50 is being revised so that it is consistent with the pricing of the conscious sedation codes under the Medicare physician fee schedule and CPT coding guidelines. The new policy is as follows:
>
> If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines.
>
> If the physician performing the procedure also provides local or minimal sedation for the procedure, then no separate payment is made for the local or minimal sedation service.
>
> The carrier shall follow the NCCI edits imposed for codes 99143 and 99144 if billed with any procedure in Appendix G of the CPT.

On the disputed date of service, the requestor also billed codes 64635, 64633 and 64636. These codes were not listed in Appendix G of the CPT.

The CPT's rules and guidelines regarding Moderate (Conscious) Sedation states that "Intraservice time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation." Per the CPT code descriptor both 99144 and 99145 are timed codes; therefore, the documentation must note when the service starts and ends.
A review of the submitted documentation finds that the requestor wrote "IV conscious sedation was administered by anurse trained in conscious sedateion and was overssen by Dr. Reinsmith." The report does not support the time spent performing the procedure; therefore, the respondent's denial for codes 99144 and 99145 based upon "X164" and "150" is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/17/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.